SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: LG.ER.11.GS.AR	SERFF Tr Num: UHLC-127324748	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 49308
Sub-TOI: H16G.002A Large Group Only - PPO	Co Tr Num: LG.ER.11.GS.AR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Kelly Smith	Disposition Date: 07/20/2011
	Date Submitted: 07/15/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: LG.ER.11.GS.AR	Status of Filing in Domicile: Not Filed
Project Number: LG.ER.11.GS.AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 07/20/2011	
State Status Changed: 07/20/2011	Deemer Date:
Created By: Kelly Smith	Submitted By: Kelly Smith

Corresponding Filing Tracking Number: LG.ER.11.GS.AR
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:
These forms are our standard Employer Application and Enrollment form which will be utilized for products that provide an international level of benefits. These forms have been prepared for use for large groups only for medical, dental, vision and ancillary coverages.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Kelly Smith, Manager RGA
800 King Farm Blvd.
Suite 500
Rockville, MD 20850
Kelly_Smith@uhc.com
240-632-8061 [Phone]

Filing Company Information

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
185 Asylum Street	Group Code: 707	Company Type: Life and Health
Hartford, CT 06103	Group Name:	State ID Number:
(860) 702-5000 ext. [Phone]	FEIN Number: 36-2739571	

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	$20.00 form filing fee x2
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	$40.00	07/15/2011	49830265
UnitedHealthcare Insurance Company	$60.00	07/19/2011	49901154

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/20/2011	07/20/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	07/18/2011	07/18/2011	Kelly Smith	07/19/2011	07/19/2011

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Disposition

Disposition Date: 07/20/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter - LG.ER.11.GS.AR and LG.EE.11.GS.AR	Approved-Closed	Yes
Form	LG.ER.11.GS.AR	Approved-Closed	Yes
Form	LG.EE.11.GS.AR	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/18/2011
Submitted Date	07/18/2011
Respond By Date	

Dear Kelly Smith,

This will acknowledge receipt of the captioned filing.

Objection 1

- LG.ER.11.GS.AR, LG.ER.11.GS.AR (Form)
- LG.EE.11.GS.AR, LG.EE.11.GS.AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $100.00. Please submit an additional $60.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/19/2011
Submitted Date	07/19/2011

Dear Rosalind Minor,

Comments:
The filing fees under Rule and Regulation 57 update is noted.

Response 1

Comments: Additional filing fee requirement is satisfied under the Filing Fee tab.

Related Objection 1

Applies To:

- LG.ER.11.GS.AR, LG.ER.11.GS.AR (Form)
- LG.EE.11.GS.AR, LG.EE.11.GS.AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $100.00. Please submit an additional $60.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your attention in review of the filing.

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
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Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Sincerely,
Kelly Smith

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Form Schedule

Lead Form Number: LG.ER.11.GS.AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/20/2011	LG.ER.11.GS.AR	Application/Enrollment Form	LG.ER.11.GS.AR	Initial		50.200	LG.ER.11.GS.AR app.pdf
Approved-Closed 07/20/2011	LG.EE.11.GS.AR	Application/Enrollment Form	LG.EE.11.GS.AR	Initial		52.500	LG.EE.11.GS.AR.pdf

Insured Employer Application
UnitedHealthcare Insurance Company

UnitedHealthcare® International

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

General Information

Requested Effective Date (mm/dd/yyyy) _____ / _____ / _____

Group's/Company's Legal Name

Street Address			Tax ID	
City		State	Zip Code	County
Contact Person	Telephone	Fax	Email Address	
Billing Address (if different)			# of Years in Business	
Multi-location group/company? ☐ Yes ☐ No	# of Locations	Address (es) (or list on additional sheet of paper)		
Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other _____		Nature of Business	Industry Code	
Waiting Period for new hires ☐ 1st of Policy Month following Date of Hire ☐ 1st of Policy Month following ___ [months] [days] of employment ☐ Date of Hire (no waiting period) ☐ ____ [months] [days] of employment following Date of Hire ☐ Other _____		Waiting Period waived for initial enrollees ☐ Yes ☐ No	Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year	ERISA Plan? ☐ Yes ☐ No
Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents)	Number of Employees Termed in last 12 Months	Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners		
Name of Workers' Compensation Carrier		Names of Owners/Partners not covered by Workers' Compensation		

☐ By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic EE Life/AD&D		Basic EE Life/AD&D		Basic EE Life/AD&D		
# Hours per week to be eligible** _____		Basic Dep Life		Basic Dep Life		Basic Dep Life		
		Supp EE Life/AD&D		Supp EE Life/AD&D		Supp EE Life/AD&D		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		LTD		LTD		LTD		
		Other		Other		Other		

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

☐ Yes ☐ No	In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
☐ Yes ☐ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins a leave of absence? ☐ Yes ☐ No

(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Long-Term Disability Carrier	☐ None			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?

☐ Yes ☐ No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?

☐ Yes ☐ No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?

☐ Yes ☐ No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?

☐ Yes ☐ No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?

☐ Yes ☐ No 6. Is any employee or dependent currently hospitalized?

☐ Yes ☐ No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?

- ☐ Cancer (any type)
- ☐ Lung disease or respiratory problem (any type)
- ☐ Heart disease or disorder (any type)
- ☐ Organ, tissue or cell transplant
- ☐ Liver disease (any type)
- ☐ Kidney disease (any type)
- ☐ Pancreatic disorder (any type)
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Morbid obesity
- ☐ Congenital abnormality
- ☐ Vascular disease (any type)
- ☐ Neurological disorder (any type)
- ☐ Immunological disorder (reportable types)
- ☐ Alcohol or drug addiction or abuse

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question Number	Check One Employee	Check One Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	$ Amount of Claims	Current Treatment

State Mandate Offers

Arkansas statutes require the optional coverage listed below to be offered to each group. The group can separately accept or reject the "mandated offer". Your Broker or agent can provide you with additional information, including any additional premium amount required for the mandated offer. Please note that not all mandated offers are listed below; some mandated offers are standardly included in UnitedHealthcare plans.

Please use the checkboxes below to indicate your acceptance or rejection of the "mandated offer".

☐ Accept
☐ Reject

Optional coverage for musculoskeletal disorders of the face, neck or head, as described by Arkansas Statute 23-79-150

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions, misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's employees.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:
*We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (Form must be signed)

Group/Company Signature _____ **Date (mm/dd/yyyy)** ____ / ____ / _____ **Title**_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

Broker Name	Agency	Agent Code/Tax ID Number		
Signature	**Email Address**	**Social Security #**	**Phone Number**	**Date**
Rep Name		**Rep #**		
Commissions payable to		**Broker Commission Schedule** _____ **Std Scale of** _____ %		

Enrollment Application/Change/Cancellation Request
UnitedHealthcare Insurance Company

UnitedHealthcare International

P.O. Box 740111, Atlanta, GA 30374-0111
Fax: 877-370-4150

☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change____ /___ /____ (mm/dd/yyyy)

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation Medical _____ Vision _____
Dental _____ Life _____ AD&D _____ LTD _____

Reporting Code Medical _____ Vision _____
Dental _____ Life _____ AD&D _____ LTD _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___ (mm/dd/yyyy)
If non-U.S. Citizen - Employee Number _____
Requested Date of Coverage ___ /___ /___ (mm/dd/yyyy)
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date_____
☐ **Annual Open Enrollment**
Requested Effective Date of Enrollment ___ /__ /___ (mm/dd/yyyy)

☐ **Cancellations:** Last Date of Employment ___ /___ /___
mm dd yyyy
Requested Effective Date of Cancellation ___ /___ /___
mm dd yyyy
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Signature	Date
Employer Position	Phone

A. Employee Information

Social Security Number (US only)	Birthdate / / mm dd yyyy	Sex ☐M ☐F	Last Name	First Name	MI

Assignment Residence Address | Apt# | City/Town | State/Region | Area Postal Code | Country

Home Phone | Work Phone | Cell Phone

Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other–Please specify
*Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Preferred Mailing Address ■ Check if same as above

Street Address | Apt# | City/Town | State/Region | Area Postal Code | Country

Other information:

E-mail Address	Preferred Communication Type: ☐ E-mail ☐ Phone ☐ Mail	Resident of

Language preference if not English	Citizen of

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | ☐ Spouse ☐ Domestic Partner (if eligible) | Birthdate / / mm dd yyyy

Preferred mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_|

Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_|

Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_|

Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_|

Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) |_|_|_|–|_|_|–|_|_|_|_|

Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

*Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their health and well-being and not for eligibility or claim payment determination.

**For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	LTD	Life/Amount	AD&D	Dual Option Selected
Employee	☐	☐	☐	☐	☐ $ ________	☐	☐
Spouse	☐	☐	☐		☐		
Domestic Partner	☐	☐	☐		☐		
Dependents	☐	☐	☐		☐		
					Salary ________ Required only if Life Plan based on salary		

Life Insurance Beneficiary's Full Name and Address	Relationship

[XXX-XXXX 6/11]

D. Reimbursement options

Pay Member

☐ Use banking details on file ☐ Payment by check ☐ Electronic funds transfer payment

Specify currency for reimbursement _____ Note - If no selection, reimbursement will default to a US dollar check

For bank transfers please complete the following:

Bank name _____

Bank address _____

SWIFT / BIC Code _____

Beneficiary routing code _____

Account number / IBAN _____

Account name / Payee _____

E. Other Medical or Other Country Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical or country health plan or policy, including another UnitedHealthcare plan or Medicare?

☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier or other country coverage:

Other Group Medical or Other Country Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

* B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

F. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

G. Signature

I confirm that the information I have provided on this form is complete and accurate.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage) (Spouse may include a Domestic Partner, depending on your benefit plan)

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

[XXX-XXXX 6/11]

SERFF Tracking Number:	*UHLC-127324748*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*49308*
Company Tracking Number:	*LG.ER.11.GS.AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*LG.ER.11.GS.AR*		
Project Name/Number:	*LG.ER.11.GS.AR/LG.ER.11.GS.AR*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	07/20/2011
Bypass Reason:	Both form filing scores are noted in the cover letter LG.ER.11.GS.AR: Flesch scores of 50.2 LG.EE.GS.AR: Flesch score of 52.5		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/20/2011
Bypass Reason:	not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/20/2011
Bypass Reason:	Not applicable		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter - LG.ER.11.GS.AR and LG.EE.11.GS.AR	Approved-Closed	07/20/2011
Comments:			

Attachment:

2011 Enrollment Form Cover Letter.pdf

July 15, 2011

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: UnitedHealthcare Insurance Company
NAIC No. 79413

Enrollment/Application Filings

Dear Ms. Minor,

On behalf of UnitedHealthcare Insurance I am submitting the enclosed enrollment/application forms for your Department's review and approval. A listing and description of the forms, along with the Flesch Scores, has been provided below for your reference.

Form Number	Description	Flesch Score
LG.ER.11.GS.AR 6/11	**Employer Application**	**50.2**
LG.EE.11.GS.AR 6/11	**Employee Application**	**52.5**

These forms are our standard Employer Application and Enrollment form which will be utilized for products that provide an international level of benefits. These forms have been prepared for use for large groups only for medical, dental, vision and ancillary coverages. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments. We want to assure the Department that education will be provided to the brokers, employer groups and the employees as to which products are being offered for sale.

If you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

Kelly Smith
Manager, Regulatory Affairs

Kelly_smith@uhc.com
Phone: 240-632-8061